The Sleeper in Health Reform: Long-Term Care and the CLASS Act
Kaiser Family Foundation
October 20, 2009

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DIANE ROWLAND: I hope you're all wide awake, so we can talk about the sleeper issue, and that we don't put you to sleep. Today we're going to be discussing what we've labeled "the sleeper issue" in health reform, long-term care, and The CLASS Act.

I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation. And we're pleased to welcome you here to the Barbara Jordan Conference Center for this discussion.

We are awaiting one of our panel members. We learned a long time ago, when you schedule a briefing and you have someone coming from the Hill, you always have to be a little nervous about when that individual will get here. So we are starting this briefing with the same sense of tension that we always have when we have a guest who's missing. But we're sure that Connie Garner will show up very soon.

What we'd like to do today is to really talk about an issue that too often gets put on the back

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burner; that too often is not part of our discussion. And many who have been following the health care reform debate, and who have been looking at the news coverage of health care reform, would note that there's very little mention of the issues that face so many of us. And so many of us as we age, and as we deal with our aging parents, which is the need for long-term care assistance; and the way to try and provide those services and finance those services.

So we're very pleased that there are provisions in the health reform bill that haven't necessarily gotten a lot of media and public attention that could help to address some of these concerns. Today we've put together a large, but a very well-informed panel, to talk about the issues in the CLASS act and the issues around long-term care reform. And for those of you who know the other CLASS act that's in the House, about cultural and linguistic access, this is not that discussion. [Laughter]

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DIANE ROWLAND: This is the discussion about The CLASS Act that deals with long-term care services. So I'm going to start by asking Judy Feder, a professor of public policy at the Georgetown Public Policy Institute, and senior fellow at the Center for American Progress, to give us a little bit of a framework about why we're talking about long-term care.

Then we're hoping to be able to turn to Connie Gardner, the Policy Director for Disability and Special Populations on the U.S. Senate Help Committee, which has had a major role in of course drafting the provisions of the CLASS Act, to review what the act is about.

And then Paul Van de Water, a senior fellow at the Center on Budget and Policy Priorities, whose vast experience with CBO analysis and budgets can talk to us a bit more about its impact on the budget and the financing.

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So that's the basic framework that we'd like to start with. And then we're going to turn after these openings remarks to some perspectives from our panel. And I'll introduce them as we get to that point. Their full bios are in your folder, as well as a short summary of the CLASS Act, and some other materials. And with that, I'll turn to Judy, and she can kick us off. Thank you.

JUDY FEDER: Thank you, Diane. It's a pleasure to be with you. And I think there's a long-term care crowd here and broader. But to the long-term care crowd, I would say what's taken us so long? And isn't it a terrific moment to be talking about long-term care reform as part of health reform. And in true Kaiser fashion – and I think a very good philosophy we're going to start with thinking about the people who need long-term care, so that we always have people in our minds as we talk about policy.

The long-term care population numbers, it's estimated, about ten million people; people who need help with services and supports because they are not able to function and live their daily lives without that help. What is important to remember is that most of them are in the community, living in the community; most of them supported by family members.

It is also often a shock to people who think about the need for long-term services and supports as associated with older people to recognize that over 40 percent of people who need help with activities of daily living are under the age of 65. So keep that in your minds.

It is also important to remember that there is a tremendous variation in the kinds of people, or the circumstances that make people have a need for assistance with tasks of daily living, and in the services that people need. Conditions can vary from people with developmental disabilities, spinal cord

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injuries, to dementia and mental illness; tremendous variation.

And the tasks that people need help with also vary from shopping and getting around to very fundamental needs in terms of bathing, eating, dressing one's self, functions that are absolutely necessary to survival. Long-term services and supports are about helping people manage their daily lives.

And here's Connie. And Connie, just come on up whenever you're ready here. You're right next to me. And it means I don't have to talk slowly, which you know is very hard for me [laughter].

Okay, so, all right now, as I said, most of the people who need long-term services and supports are living at home, getting help from their family members. But only a modest proportion are in institutions. But when you need – when you're depending only on family members, evidence tells us that you are more likely to have substantial unmet needs. And your family members

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are often making extraordinary sacrifices in order to take care of you.

So there's a tremendous need for assistance – for paid assistance. And the problem that we have is that it costs a lot of money. And when I say that, I want to not belittle that, because the long-term services and supports workers need to be decently paid. So it is expensive to get support services.

And what you can see here is that nursing home costs are really substantial, over $76,000 for a nursing home with a private room; close to $70,000 for a semi-private room. You also see, then, the bar on the right, the cost for assisted living. And the cost of hourly costs in the column on the left of services at home, when you need services and it's close to $20 or $30 an hour, it's very expensive for people to sustain, particularly since most – certainly older people, and younger people even more so actually, with

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disabilities, are likely to have modest — disproportionately modest incomes. So it is expensive.

And that takes us to our financing system. The problem with long-term services and supports and its financing is that unlike our health care system, we really don't have an insurance system to support long-term services and supports when we need them. Much of the spending is out-of-pocket; you see on this slide 22 percent. Although this slide somewhat exaggerates what's contributed by Medicare, because although Medicare pays for services at home, and in institutions, they are services needed most often when people have an acute illness. So most people pay out-of-pocket for long-term services and supports.

We have very little private long-term care insurance. It's been a fledgling industry for 30 years. It has not taken off, so it does not pay much of the bill. The reality about financing long-term services and supports is that we pay for most of it out

of our own pockets. And it is only after we have exhausted all our resources that Medicaid kicks in.

Medicaid is enormously valuable to us when we need long-term services and supports. It is our safety net. But unlike most insurance that protects us against financial catastrophe, it kicks in only after catastrophe has hit, when we really have exhausted everything else. And a major concern, which is also addressed in the policy on the table, is that it disproportionately favors services in nursing homes as opposed to at-home and in the community. Although that has improved substantially over the years, it hasn't improved enough to enable people to have support when they most want it and need it, which is at home.

So that's the background. And just before I turn it back to Diane, I just want to quickly mention what health reform is ready to do about it, because it is a sleeper. And the CLASS Act is where we want to devote most of our attention this morning. But in the

Senate Finance Committee mark, we also have provisions that will improve home and community based care in what's called the Community First Choice Act.

We have enhanced funding to states that are moving and have a great need to move more in the direction of supporting services at home and in the community. They have too great an emphasis on institutions. We have support for innovations in the delivery of care to people who need long-term services and supports through coordination of care in Medicaid, through coordination and integration of Medicare and Medicaid services through a focus on what we call dual eligibles, beneficiaries enrolled in both the Medicaid and Medicare programs. And we have an agency to improve that coordination.

We also have inclusion of long-term supports and services in the Medicare delivery reforms and payment reforms that are on the table. And most importantly, in shifting our financing system, we have

the CLASS Act, which constitutes a real shift to an insurance system by enabling us at younger ages, when we do not have a disability, to put away money to contribute to an insurance program that will be there when we need it.

It is a non-means-tested program that enables us to deduct from – to put away money – out of our payroll. After we contribute for five years we become entitled. We have earned a benefit which will be described, that will be available to us when we – when and if we encounter a disability. It is a cash based structure focused on enabling us to purchase services at home, as I've described.

So in all respects, it has the potential to move us in the direction that many of us have been looking to for a very long time, which is to create a meaningful insurance mechanism for people who need long-term services and supports. Thanks.

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DIANE ROWLAND: Thank you, Judy, for that set-up. And thank you, Connie, for arriving in time [Laughter] for your explanation of the CLASS Act, the motivation behind it, and what you think it will accomplish.

CONNIE GARNER: Thank you for having me. As you know, I've been with — was with Senator Kennedy for almost 16 years. And one of the issues that was very, very important to him, and we will continue to move this forward, both because it was important to him and because the rationale behind it made sense, was that when we talk about health care reform, it should not be only about acute illness and injury.

It should not be about only covering the uninsured. But it also should be about looking at what individuals need in terms of services and supports to bring them to equal, to be able to have some choices about their life, and be able to participate in solving their own issues ahead of time.

And so we began looking at the CLASS Act as a model back in 2003, actually; and got involved with Senator Grassley, originally with that model. He at that point chose – after we got a little bit further along, to say that he wanted to put some effort into tax credits, which he did. And Senator Dewine, at that point in time, from Ohio, picked up the mantel. And Senator Kennedy and Senator Dewine introduced a model of the CLASS Act back in 2005.

So this is not a piece that came as a result of health care reform. But it was very clear to him that it was important to think about long-term services and supports in a new and different way; and to think about long-term services and supports as a health issue, not as a disability issue. And although it affects people that have functional limitations, regardless of what their age is, we all know that disability insurance, whether it's public or private, is about income replacement. It's not about offering

people financial structure for the services and supports they need to stay at home, live in their community, go to assisted living, be able to have some support if they do have a nursing home bill as well.

This is intended to be used across the continuum. We hope people will be able to have more options at home and in their community. But if they need this resource for assisted living, or another type of a placement, it's available for that use as well.

We began to look at this really as a result somewhat of what Judy talked about. We had spent a long time looking at issues around disability and functional limitation, and began to get very concerned about the paradigm in this country that actually says in order to get what you need, you really need to be poor, and you need to be significantly, functionally limited. You see that across the board. You see it in SSI, SSDI, Medicaid. You see it almost, I would argue, in Special Ed. as well. And that tends to be the

direction that we go in the public policies that we have.

And so what we began to look at was why do we do that? Why? And for me personally, I will tell you it is a huge issue. Because as a number of you know, I'm a practicing pediatric and neo-natal nurse practitioner. So every time the Gerber baby's not the Gerber baby on Friday night, and we begin to think about what's the life and the quality of life of that child and their family going to be, it brings in this issue, even way back then, of long-term services and supports to bring the child in that family to equal, so they have some quality of life; so they can work; so they're not commissioned to stay home on social security and watch TV all day long.

And that applies whether it's a young person coming up through the continuum, or whether it's an older person, or whether it's a person under 65 who has

an untoward circumstance occur, or whether it's one in the aging community.

I will share with you also from a background point of view, it's very interesting for me having a nursing background, when I went back to do my Master's in nursing, I wanted to do it in long-term care of kids with cardio-pulmonary and neurologic disorders. And I can remember going to the University of Penn to apply for the program and having the Nursing Department say long-term care is nursing homes. Long-term care is about nursing homes. You don't connect long-term care with kids.

And the fight that went on for almost six weeks about that, before finally there was a notion that, yes, there did need to be continuing care thinking that went on with children who had disabilities or functional limitations, and so I was able to pursue that, but not without a fight. And that became the thinking around this issue of the word, and

the terminology even, long-term care, because long-term care for the general public is associated with nursing home.

We took that term and said that's a place, not a process. And what we want to do is look at long-term services and supports, irrespective of where those services and supports take place, and see if we could twist the paradigm so that it was about individuals with functional limitations; whether they were under 65, or whether they were over 65. And our argument is that that will jump start a marketplace that, as Judy says has really been in difficulty, having challenges for the last 30 years.

So we began to look at that, and particularly through the lens of Medicaid. And was it really fair in this country? Was it really fair to have essentially the only game in town being Medicaid, when you needed to have some kinds of services and supports?

So we began to look at what the other options were that were out there.

And as we did look at the private insurance industry, which has a variety of products, and which does have some very entrepreneurial products, we would argue. We began to look at where are they in the marketplace?

And from the period of time of 2003, when we began to look at this, to currently, that marketplace, and the penetration in the marketplace has really dropped significantly, to around now a little under five percent.

So what that tells us is if the penetration is only close to five percent, then the rest of the country either has to have enough resources to take care of themselves, because Judy's already talked about Medicare, and short-term hospitalization that it pays for, and rehab. So you either have to have enough money to pay for yourself, or you're going to gravitate

towards Medicaid. And we all know by looking at the state Medicaid budgets that this becomes the largest expenditure, out of state Medicaid budgets.

So we began to say there has to be a different way to do this. We're giving a bad message to those who have been very responsible with their life. We're giving a very bad message to the industry that works, the hospitals and the doctors who try very hard to keep people alive. It gives a very bad message to the parents, again, that I see on a Friday night, when the Gerber baby isn't the Gerber baby.

And so what are we really doing in this country, if that's the message? So we began to look at a different model and said what is it – we needed to try to accomplish two things. Is there a way to address this issue so that people who do develop functional limitations, or have them, have a resource for the services and supports they need, so they can stay at home, so they can still go to work. So they

don't have to be caught with their disability insurance. And this is not a slam on it. It's just the way it is – caught with their disability insurance, and when they go back to work at 7-11, their income replacement stops.

And we needed to have a different kind of a model that we looked at. So we began to look at how do you develop a model that really capitalizes on pooled risk, and make it voluntary opt out. And that's what the two kinds of cornerstones of this legislation are.

So what we say in it is it applies to individuals 18 to 65, 18 on up, and what we say is that when you can become enrolled is when you're actively working. And our definition of actively working is not very hard. Our definition of actively working is one quarter worth of work, and it really comes down to about a $1,000 a year.

Now people will say why do you have such a low threshold for work? And the reason is because we want

to make sure, given that this plan is a little bit different than the private insurance plans, in that there is no underwriting. Let me say that one more time. There is no underwriting in this kind of a program.

And this is going to become the rationale for why the way the structure — financing structure looks a little bit different, why the premiums are what they are. But there is no underwriting in this program. And there's also a program, thanks to amendments that we received actually from the republican side of the senate, when we marked it up in the Help Committee that asked that that premium be set so that there was 75 year solvency from day one.

So you have a premium that once it's locked in it doesn't change for the lifetime of what you have. But your benefit continues to go up with inflation every year. So in terms of the quality of the product, and that was already scored four or five times, so we

know that we are clear on the model. We are clear on the solvency of the model. And we're clear on the methodology for which it was done.

So we felt like we would have a pretty good product there. So you do enroll in it when you're actively working. And that means that if you are a person who has a disability right now, and you enroll today, then you'd need to pay in, as everyone else does. There is a five year pay in waiting period, before you can trigger your benefit.

And people say why did you do that? Well, the reason that we did it is two-fold. One was you need to have a pool big enough to be able to offer what we're offering, which is no underwriting, and your benefit for life. It's not a three year policy. It's not an equivalent of a three year policy. It's not a five year policy. It doesn't have a limitation on it.

So in order to do that, you have to have the most people you can in that risk pool. And you also

need to have as much money as you can build up in that pool. That was the first reason for the five years. The second reason for the five years was we really want to make sure that we have a program that people are going to invest in.

We need to have that snapshot in time of how many people enrolled, what's our participation rate, what's our adverse selection, meaning how many people in it are challenged by an issue right now? We need to have all that before we begin paying out, so that we're not signing people up for something that looks like it's not going to work.

We have frontloaded the system, with incentives for those who get in, their first eligible year, or the first year of the program. And you can still get in after that. But if you do, you're going to get hit with – I don't want to say penalties, but you are going to get hit with a higher premium as a result of coming in later.

So that's the reason. People have asked what's the reason for the five years. That's the reason for the five years. It was done from a responsibility point of view on our part to take a look at what really happens here.

So let's say that you paid in for your five years, at which point you have either already have a disability, or you have an untoward circumstance. Let's say you fall off the ladder taking your Christmas lights down. If you are found to have a functional limitation or disability, and that needs to be confirmed by a medical doctor, but does not need to work under a medical plan. Let me make that clear; does not have the restriction of a medical plan attached to it; does need to be confirmed by a medical personnel. And you're found to have a limitation that's anywhere from two activities of daily living or the cognitive equivalent of that on up. Then you would qualify for your benefit.

What we've done in this model, the financing piece of it, is ask that HHS be able to have the flexibility to remodel this as they see what that premium pool really looks like. Because what the secretary has to work with over the period of years is the premium she collects, the compounding nature of that premium, and also the interest that's afforded by the premiums as well.

She needs to be able to look at that and then remodel after this bill's passed. So what we do is put three parameters in. The first one was to say you will never, ever be able to offer a benefit to anyone that's less than $50 a day. That's $1,500 a month. And again this is a cash model. And I'll come back in a minute to why we chose to do a cash model, but it's $1,500 a month.

Now there are some that will say that's not enough. Please let me reiterate as we have in other conferences, this particular proposal was never meant

to be the be all, end all of long-term services and supports. It was never meant to replace or compete, frankly, with the private insurance industry.

What it was meant to do is to give a financial backdrop that one could contribute to, so they would have something, whether they were under 65 or over 65, that didn't impact their eligibility for Medicaid or Medicare, didn't impact their eligibility for SSI or SSDI. It's an insurance based model that they contribute to, so that when they, as part of that pool, trigger functional limitation, they're able to collect that benefit.

So this is never meant to take the place of other long-term services and supports programs. There are those who will say well, $50 isn't enough. We've done our research on the number of private insurance products that are out there that actually do offer a $50 a day benefit, and the number of people who do buy it.

So it is a product that's offered out in the field. Is it one that everyone buys? No. Is it one that is probably the most attractive? No, because if that's all you have, then $1,500 a month may not be enough. But it is $50 a day, and as one of the senators said in our mark up, $1,500 a month would have made a big difference to her when she had a functional limitation and couldn't get to work, even if it was just in terms of transportation.

So we're giving people choices. Do you sit home? Or do you do the best you can to be brought to equal, so that you can continue to be functional and be part of your plan for your life. But we said $50 a day was the minimum benefit. You could never offer less than $50 a day.

But we want to develop a scale that goes up from $50 a day, concurrent with whatever the level of limitations, or degree of limitation is that a person would have. So that could be $50 a day, $75 a day,

$100 a day. It could be two functional limitations. The Secretary could start it at three functional limitations, activities of daily living or the cognitive equivalent. And as you know, there tends to be a difference between two and three limitations when you get into the physical needs.

So that was the one parameter. We said you can start – you can never give less than two ADLs. You can never give less than $50 a day. And then we needed to come up with a premium, at which point, Senator Gregg did put an amendment on that and asked for the 75 year solvency.

And our latest score that we have on this, as CBO chose to take a snapshot of $75 a day benefit, which is $2250 a month. And that premium for life, no underwriting, and a benefit that goes up by CPI every year, be $120 to $123 a month. Within that, we have subsidized, internally subsidized, people who are a hundred percent of poverty or less, and students 18 to

23 years old, who are meeting that $1,000 a year requirement. And there's a reason for that. And I'll close with that piece, and then we'll take some questions.

In the process of putting this together since 2003, we've done a number of focus groups with young people around the country, and the end of that is now 22,000. And the questions that were asked in those focus groups to the students revolved around four issues.

Number one, do you honestly think anything – do you have a sense that this is something that's important to you? And what the students reported, which I've often said was a little bit of a surprise to me, and I have seven kids, was yes, they had much more of an appreciation that they may not be who they are 24 hours from now. They had seen lots of kids with car accidents, boogie board accidents; they reported that

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they had more friends that had Special Ed in school. They were much more exposed to that.

And I would have to say that the whole piece of HIV-AIDS that's happened in the country has really raised their level of awareness. They reported as to the fact that they may not – they can't predict who they're going to be 24 hours from now, just like no one sitting in this audience can. So that was the first thing.

The second thing was is this a program they would invest in as a newly employed person out of school? And they said yes, but it was dependent on the premium. And what they really wanted was the $65 a month premium, which is why you saw us try to build the first bill around $65. It really came from them. They are the healthy risk pool. They are the individuals who will contribute to a pool for those who need it. But that didn't work out too well.

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We weren't able to do it at $65 a day in a reasonable way from CBO cost estimate. You could, but it would be a little bit of a question in the second and third decade.

The third thing we asked them was what kind of a benefit would make sense to you — and this is where we got to the issue of long-term care equals nursing home. When we talked about long-term care products, they immediately said that's a nursing home. When we talked about long-term services and supports, it has another kind of connotation.

And so they said we need a cash benefit. That way it works for me if I have an accident in a ski resort up in Colorado. And it also works for my family because what they reported when they went home was it was a lot of conversation about what are we going to do about Grandma.

So it was almost as if generationally those conversations began to line up. Consequently, we have

a cash model. What we did with respect to the students, because we wanted to build their sense of personal responsibility, their sense of continued understanding that they can't predict who they're going to be 24 hours from now, was to allow them to have that if they're in school, and they're meeting that $1,000 a year criteria for $5. So the students and those a hundred percent of poverty or less are internally offset by the score that we have.

So that's pretty much how the program works. We have 275 national groups on it, all the unions, the aging community, the disability community, a lot of the provider groups. And we have an awful lot of support in the Congress for this right now.

As you know, the House bill does have it in. The Senate bill and the merge conversations is continuing to discuss it. And we're hoping that in the end of the day, as everything twists and turns, we'll be able to see some notion of this come out.

And if this doesn't work, somebody really needs to think of something that does, because it is absolutely unfair in this country to give the message out there that if anything happens to you, and that's everyone in this audience, and I see it every time I go and work over at the hospital, I see it. Everybody in this audience that has no idea where they're going to be 24 hours from now needs to take the issue for real.

And if we don't do something, whether it's this model or another model, everybody is going to be commissioned to being poor and significant in order to get what you need and on Medicaid. So any responsibility you've had to save money over the years, for your kids, for your retirement, is shot, unless we come up with some other way.

Now, in closing, let me say that we have always and continue to say that we want to work in conjunction with the private insurance industry on this, and create something similar, as Senator Conrad

said at one of our meetings last week, to what some of the European models have looked like, in terms of health care, and for our purposes long-term care. The French model we have looked at, where they have this kind of a base cash benefit.

And it's actually increased the entrepreneurial wrap around products that the private industries developed over the last five years. So we want to try to work with the insurance industry. There's a lot of tug and pull there, as you would expect. But we would hope they would come to the table and have some conversations about how to make this work for both the public and the private sector. Thank you.

DIANE ROWLAND: Thank you, Connie. Paul?

PAUL VAN DE WATER: Thank you, Diane. Connie Garner and Senator Kennedy have provided inspiration and leadership on this issue for many years. And we owe them a great debt of thanks. My job is much more prosaic. I'm not so good at inspiration, so I get to

talk about budgets [Laughter]. And since that is less interesting, I'll try to be brief.

There's been a lot of confusion, I think, about the potential budgetary impact of the CLASS Act; in part because, as Connie said, the bill has undergone substantial changes and improvements as it went through the Help Committee process.

Some of you may have seen an estimate that the Congressional Budget Office issued in early July. That estimate referred to the earlier version of the bill, and doesn't reflect a number of the improvements that Connie mentioned. Similarly, there was a letter from the American Academy of Actuaries later in July, which also to a large extent, although not entirely, reflected the original version of the bill.

The later version of the bill, however, as Connie said, includes the provision which requires that the secretary of HHS in developing the CLASS Act insurance program assured that the program is

financially sound and solvent over a 75 year horizon. And the Congressional Budget Office has affirmed that that is feasible and possible. And Connie talked about the estimate that they've produced, which says that with a level premium of approximately $123 a month, one could finance the $75 per day benefit.

And I should say that CBO is not alone in that. In the Academy of Actuaries letter, which they sent to the Help Committee in July, the academy did say quite clearly that there is nothing standing in the way of refining a proposal like the one Connie has described, to make sure that it is voluntary and actuarially sound over a long time period.

Connie's mentioned already some of the key features of the bill that enable this to be the case. Because there is no underwriting, as there might be in private policy, the bill instead provides this employment related test. And the actuaries indicate that that's an important requirement to make sure that

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there is some limitation, to make sure that the risk pool does include healthy people in a way to keep the program sound and sustainable.

And of course the secretary then, if need be, is authorized, in fact required, to adjust premiums in future years, if adjustments are required to assure solvency.

What are some of the key features of the estimate? Of course in a program like this, and Connie has hinted at this also, because people would pay premiums up front, but wouldn't become eligible for benefits for at least five years; and one hopes in most cases for many years beyond that, there is an obvious cash flow pattern to the program, namely premiums come in early on, before many people have become eligible for benefits. But benefit payments don't start to go out for the most part until a number of years down the road.

So the program, which would operate through a trust fund like social security or Medicare, would build up balances in the early years, and in later years, those balances, including the interest earned on the initial premiums plus additional premium contributions coming in, would be used to pay for the benefits. And because of the solvency requirement and the flexibility given to the secretary of HHS, those premiums plus the interest on them, will be sufficient to pay the benefits over the long run.

Now, of course budgetary issues are never quite so simple as this, because for a trust fund program, there are two perspectives. One is looking at the trust fund itself; secondly, seeing what the program looks like in the context of the entire budget. And in that larger context, putting aside the interest earned on the trust fund, which is an intra-governmental and intra-budgetary transaction, you see in the CBO cost estimate that the CLASS Act, taken by

itself, serves to reduce the deficit in its early years because of premiums coming in; but then adds to spending on net in the long run.

One of the key questions that's being considered in the context of health reform is whether or not those receipts in the early years should be viewed as what's sometimes termed an offset to the cost of health reform in the early years. And again like most budgetary questions, that has at least two answers [Laughter].

From a technical point of view, there's certainly nothing – in my view, there's nothing wrong with counting the premiums received from the CLASS Act in its early years as an offset to the initial cost of health reform in its early years, as long as one recognizes that the additional benefit costs over the longer run also need to be covered. And in a sense I think the cash flow patterns of health reform and the CLASS Act are complementary, in that we know that one

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of the goals of health reform generally is to slow the growth of health care costs in the long run.

Judy has written a lot about that. You know about that. And to the extent that health reform may help to bend the cost curve of the long run, that actually fits nicely with the CLASS Act and enables it to cover some of the benefit costs in the long run. Although I should say that the benefit costs of the CLASS Act in the long run are not going to be overwhelming in any event.

All of that having been said, saying I don't see a technical problem in doing this, one can understand that since the CLASS Act is obviously designed to be self-financing, some people said well, we just don't think it makes sense that you should count the CLASS Act as part of the income in early years and the outgo in later years for health reform. And I think that's a reasonable alternative point of view.

So my closing point would be that whether or not one views – takes the CLASS Act income in early years and the spending in later years as part of the overall income and costs of health reform. Or on the other hand, whether one elects to – whether the congress decides that it should sort of be put off to the side in its own category. Either way, the CLASS Act is set up in a way to be financially sound over the long run. It is in my view a reasonable component of health reform. And these budgetary issues shouldn't be taken as any reason not to do the CLASS Act.

And in fact, as Judy and Connie have both said, we've been talking about these long-term care issues for 20 years or more. In fact, Diane and I were involved in a discussion of this back in 1991. And I hope that we don't have to wait close to another 20 years for making progress on this issue.

DIANE ROWLAND: There was a long time ago when we thought the Pepper Commission was going to bring us long-term care reform, and that was about the same era.

So now we're going to turn with that very excellent framework of the need for long-term services and supports, the hope that the CLASS Act can bring to being able to help meet some of those needs and the financial issues with regard to it, to our panel of just terrific people, to speak from their perspectives on what this act has as its implications for the future of being able to meet the needs of our population with functional and other physical needs.

Richard Frank, Deputy Assistant Secretary for the Office of Disability, Aging, and Long-Term Care Policy at the Department of Health and Human Services; Nora Super the Director of Government Relations and Health and Long-Term Care at AARP; Larry Minnix, the President and CEO of The American Association of Homes and Services for the Aging; and Marty Ford, the

Director of Legal Advocacy for the Disability Policy Collaboration, a partnership of UPC and the ARC, are all here to share their perspectives. We're going to just open the microphones to them to make a few brief comments. And then we're going to open the floor to you to ask your questions and be able to comment. So we'll start with Richard. Thank you.

RICHARD FRANK: Thank you very much, Diane. I want to thank the Kaiser Foundation for organizing this event. We're very happy to participate.

I'm going to draw on my extensive experience in the government of seven-and-a-half weeks in making my remarks [Laughter].

FEMALE SPEAKER: It seems like longer. [Laughter].

RICHARD FRANK: It does. Judy and Connie –

FEMALE SPEAKER: Aging rapidly. [Laughter]

RICHARD FRANK: Exactly. Judy and Connie started off by really making a strong case for the need

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here. And Judy presented some good data. I just want to add a couple of items to drive the point home a little bit, and why the administration sees this as important.

The first thing is there is about 70,000 workers that have severe disability and require assistance that manage to stay in their jobs and work on a regular basis. And really this policy is aimed very much at supporting them. And Connie sort of made that point. But there are a lot of these people out there in need.

The other thing is that unpaid caregivers really are the heart of the, in a sense, long-term services and support workforce here. And about 90-percent of the people who get daily help with functional activities rely on informal care. And about 65-percent of those rely only on informal care.

And so when you have this workforce as sort of the heart of the matter, supporting them is very

important. And we know that when there's greater stress and there's less support for these informal caregivers, you raise the probability of people being in nursing homes significantly.

The second thing is that this is changing because of demographics, whereas right now we have about almost five younger people per elderly adult available in the population, that number is going to go down to under three in about 30 or 40 years.

We view the benefits of this policy as being several. First of all, we view it as a new tool, in a sense the armamentarium of how Americans will prepare for their retirement and for their elderly years, and prepare for possible catastrophes that happen in the interim, as Connie noted. And so this is a piece of that long-term financing strategy that everybody is sort of going through and developing right now, that we want to encourage people to develop.

The minimum of $50 per day, and actually the sort of expectation of a $75 benefit, means about $27,000 per year of potential resources available to people, which just to kind of put into perspective, is about one-and-a-half times the annual cost of home health care in this country. So it takes a serious chunk out of some of the financial burden.

It is set up so that it empowers consumers. And it allows people to make decisions about what works for them in their milliard, in their context. But it also has provisions in it that allow for counseling, advice and support for people as they navigate their way through a complex health and long-term care, and long-term services and support system.

Paul talked a little bit about financial soundness. And let me spend a couple of minutes on that, because that's been a point of controversy, as he alluded to.

The administration is strongly committed to having a CLASS Act that is financially sound and a program that stands on its own financial feet. As Paul mentioned CBO and our modeling has shown that staying within the parameters that Connie set out so nicely, this is doable. This is not only doable, it's been modeled many different ways and there are variations on the theme that allow a lot of flexibility but still allow for financial solvency.

Now the issues that have been raised in connection to dealing with the financial solvency are three in particular. One is adverse selection as Paul noted. Second is low participation rates and third is financial instability. As the bill has evolved, we've been very pleased to see it address these questions in a very serious way.

First, as Connie mentioned, the work requirements that are set out are very important for dealing with the adverse selection issue. In addition,

there's a five-year vesting period that is part of that. There are benefit triggers, as Connie noted, between two and three ADLs and it allows the secretary some flexibility in setting the exact trigger so that the financial solvency can be addressed on a real-time basis.

Finally, there is an important tradeoff, that Connie alluded to, between sort of the premiums you set today for the initial people and the premiums that evolve over time and again the bill allows for considerable flexibility on the part of the secretary in making future adjustments in order to maintain the financial solvency of the program and to sort of allow for premiums that will continue to support reasonable participation levels.

We've, in the department, have modeled this extensively, perhaps more extensively than anybody would want to hear about [laughter] and we're entirely persuaded that reasonable premiums, solid participation

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rates, and financial solvency over the 75-year period can be maintained. So it is, on this basis, that the administration supports it that the bill continues to sort of meet the standards of being able to stand on its own financial feet. Thanks.

DIANE ROWLAND: Thank you Richard. Nora?

NORA SUPER: Good morning everyone. I just want to say how pleased I am to see so many people here today. I'm just delighted to be here representing AARP and we've been fighting all along to keep long-term care in the final health care reform bill and there's so many of you here so I know you must share our concern.

So I'm actually, Diane gave me a fancy title but I'm actually the Chief Health Care and Long-Term Care Lobbyist for AARP. So call your members of Congress and tell them you want long-term care in the final health care reform bill because sometimes we feel lonely up there.

I do also want to acknowledge my colleague, Rhonda Richards, who's actually the expert on long-term services and supports for AARP. Those of you who work in this area probably know Rhonda. So she's told me everything substantive that I'm going to say. So if you have any really hard questions, please ask her.

As I mentioned, this has been and continues to be a top priority for AARP and our members. We hear from our members all the time about the need for long-term care and supports. The vast majority of Americans aged 50 and over, 89-percent in our surveys, tell us that they want to live in their own homes and communities as long as they possibly can.

This also resonates personally with our members who care for their aging parents. So they want to find more choices to help them pay for their long-term services and supports that help them live in their home but too often, they have to spend down all of their resources and have to rely on Medicaid because

that's really all that's there right now for most folks.

As most of us know, Medicaid has an institutional bias. It requires coverage of care in institutions such as nursing homes but home and community-based services are optional services that states are not required to cover. So in today's budgetary crises, we really are worried that many of these services are losing out and many of our members won't be able to afford the services and be able to stay in their homes, which we know is really what they want to do.

One of the slides that I don't think Judy showed is that nationally, 73-percent of Medicaid spending on long-term care services for older adults and adults with physical disabilities pays for relatively expensive nursing home care while only 27-percent goes to home and community-based services.

Yet we know that home and community-based services really are cost effective and, on average, Medicaid can provide home and community-based services to three people for the cost of serving one person in a nursing home. This is really what our members tell us they want.

So it makes more sense to be providing some of these services to people or as within the CLASS Act, actually giving people the cash to spend the services, spend the money the way they choose to. So research shows that states that invest in HCBS, over time, slow their rate of Medicaid spending growth compared to states that remain reliant on nursing homes.

People with disabilities and older adults need better options to help keep them independent and functioning at their highest level. So some important solutions supported by AARP and many, many others that we've joined with are part of health care reform

legislation and we believe must be included in any final health reform bill.

So that's why we're supporting the CLASS Act as well as what Judy mentioned, the Medicaid home and community-based service provisions that have been included in the Senate Finance Committee bill. We hope to see them in any final health care reform legislation.

We believe these provisions, which are also, the CLASS Act provisions are also, were included in the House, Energy, and Commerce bill at the end are complimentary. They meet key needs and are vital to change the current system into one that supports individual choice, control, planning, and dignity, and for millions of family, friends, and neighbors who provide support.

Connie and Senator Kennedy were big leaders who convinced many of us that this was just critically important to provide individuals a basic level of

coverage for long-term services and support without them depleting their assets or being denied coverage due to a pre-existing condition.

As Connie stressed, the cash benefit is a really important feature because it gives individuals choice and control over the services and supports they need to help them live independently in their homes and communities. Individuals could also receive the benefit as long as they remain eligible.

We think the fact that there's a large pool to spread the risk will help keep premiums affordable and the auto-enrollment design will help increase the number of individuals in the program. Importantly, one thing that AARP really stresses is that the CLASS Act will also help family caregivers who care for their loved one. The Class benefit will help pay family caregivers who work part-time or not at all because of their caregiving responsibilities.

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CLASS could also help pay for services such as adult daycare that help give caregivers a break and let them work or attend to their own needs. This is something we hear so much from our members and any of you who've had to care for family members of your own know how tiring this is, how much it depletes people of their resources, of their time and energy, and how this is just going to become an increasing burden on our workforce and all of us who are caught in the middle of taking care of our loved ones. So this is critically important.

Of course, CLASS could help delay or prevent individuals from spending all of their resources and relying on Medicaid, saving both the state's and federal government money. That's why CBO said that it saves money because they know that it will actually save Medicaid money.

So we believe that it could help provide a foundation of basic coverage for long-term services and

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supports and although it wouldn't cover all the services and supports that some individuals need, it's not meant to do so. It'll build on the CLASS benefit and together with private insurance, personal savings, other public programs, and care from friends and loved ones, the CLASS plan will help offer peace of mind to individuals and their families.

We know that education and information will be a vital part of implementing the CLASS plan and it's important for individuals to understand CLASS, how it would help them and what it would and would not do but CLASS will help millions of Americans have some coverage for long-term services and supports when now, so many have no coverage for these critical services.

I want to just take one more minute while I'm closing to also stress the importance of the Medicaid provisions in the Senate Finance proposal because as we look forward for the CLASS Act to provide for those in the future, there are those individuals who may need

home and community-based services in the short-term and who are no longer working and would not be able to pay into the CLASS program and who rely on Medicaid.

There's also Medicaid's longstanding institutional bias, as I mentioned, that prevents people from getting the services they need to help them live in their own homes and community. That's why in addition to the CLASS plan, the Senate Finance home and community-based services provisions must be included in any health care reform bill.

These provisions are critically important. There's a five-year targeted enhanced federal Medicaid matching rate for home and community-based services for states that make structural changes proven to increase nursing home diversion and access to HCBS and Medicaid. There's also the Community First Choice program, which is an option for states to provide certain home and community-based services.

There's an establishment of the same spousal impoverishment protections for spouses of individuals receiving Medicaid home and community-based services as are currently provided to the spouses of nursing home residents under Medicaid. This just makes common sense to us.

We believe that these things are critically important. When we talk to our members all over the country, this makes sense to them. They want to see it in health care reform and we really think it's critically important that we can tell them we got some long-term care services and supports in health care reform.

So in conclusion, I'd like to say that we've joined with about 50 aging and disability groups to urge inclusion of both the CLASS Act and the Medicaid home and community-based services provisions in both the merged Senate health care reform bill and the House health care reform bill.

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In July, the Scan Foundation released survey findings showing that eight in 10 people surveyed will be more likely to support health care reform if it improved coverage of home and community long-term care services.

AARP will continue to fight on behalf of our 40 million members and all older adults and people with disabilities to help make their choice to live in their homes and communities a reality, a reality that begins with the enactment of the CLASS Act and the Medicaid home and community-based services provisions in comprehensive health reform this year. Thank you.

LARRY MINNIX: Thank you. Thank you. I was asked to bring a proprietor's perspective on this issue. I represent the not-for-profit sector, mostly religious sponsorship, fraternal, labor, community organizations. I've been frequently asked gee, aren't your members upset about something like the CLASS Act because it could change the business model.

I've had zero pushback on that from provider members and in fact, amongst the groups that are supporting it, as far as I know, every major long-term care provider association favors CLASS provisions. I think that's recognition on the part of the provider community that the business model is changing.

Amongst my membership, we have to remember that 100-150 years ago, we were widows and orphans' homes, homes for the incurables, homes for old women, homes for indigent old men of good character [laughter]. We've been willing to change business models as the needs change and we're clearly in a transformational era today. So we're very pleased about that. Our board commissioned a study six years ago after Senator Baucus looked me in the eye. He wouldn't remember this but I'll never forget it.

He said give me a plan to finance long-term care differently because what we've got is not working. We spent two and a half years looking at every

conceivable way and the CLASS Act or CLASS provisions basically represent really the only way to do it on a solvent basis long-term.

We did a study through the Moran Company and Don Moran concluded that if something like the CLASS Act had been in place that included all of us as we work, Medicaid expenditures for long-term care, which are $100 billion a year and growing would be half that.

You can imagine what the health care discussion would be like today if long-term care had been essentially a consumer-funded insurance pool. So what does that do for caregivers of the future?

Let me ask you this. How many of you have been, are, or anticipate in the near future being caregivers, some older person or disabled? Okay. How many of you wrote a check for that or are anticipating writing checks out of your own pocket for that? How many of you have written checks to traditional providers in your community for those services? Not

quite as many hands. The providers of the future are, go look at your checkbook and you're beginning to see the providers of the future.

So current providers, which have, are in every community are going to find themselves becoming networks of care and caring, centers for caregiving, brokers of various kinds of services and the most, I think, important and powerful emerging professional discipline if CLASS goes through will become those people who orchestrate caregiving on behalf of other people because we have a situation in which there are 10 to 12 million seniors not counting younger people with disabilities that need caregiving today.

Seventy-percent of American families will face this. So it's not like it's an isolated set of events. So 70-percent of us will face it. That 10 to 12 million seniors that need caregiving have 35 million caregivers. So they start with a staff of three already and most of those are families. Caregiving is

a 35-hour a week job in addition to the full-time job that most caregivers already have. The substantial part of that caregiving workforce are women.

So the provider of the future is going to recognize that that's where the need is, that's where the money is if you want to have a sustainable business model, and if what a concept of putting the money in the hands of the consumer to let him or her decide how they want caregiving to be done.

Gail Hunt's organization, The Alliance for Caregiving, did a study and we know that caregivers are already spending, on average, $5,531 a year out of their own pocket, $9,000 if you're a long distance caregiver. That's two-and-a-half times the Medicaid dollars. So it's about time that policy recognizes the reality of what caregiving is all about.

So one of our people that informed us in our model of how long-term care ought to be funded for the future was a German not-for-profit countrywide, Germany

has a similar model. They're 12 or 15 years ahead of us and one of our staff asked him how did it change your business model. He said very simply, I stopped building beds and started buying vans because it turns it inside out.

Now how about a policy that is good public policy that focuses on the consumer that is solvent, that allows people choice. What's wrong with that picture? So that's where we are. From the provider perspective, I can't tell you who all my members will be a decade from now but that's my problem.

So I suspect that people like traditional providers that are smart will start working with Wal-Mart and Walgreens and Giant and Pea Pod and Comcast and so forth to begin putting together services networks that allow consumers and those people with disabilities to get care where they need it, when they need it in a place they call home.

So we're excited about the prospects of what it can do and we're excited about working especially with the younger disabled population. We had sort of this kind of a relationship but they didn't like us because they thought we represented institutions but guess what? We found common ground on basic fundamental needs and wants and the common way to finance it led us to the 275 groups that said you know this is a better way to do this.

MARTY FORD: Thank you. As Connie indicated and as Larry and others have indicated, there is a very broad coalition of disability and aging organizations working together for passage of the CLASS Act. From the disability community perspective, this is a critically important piece of legislation.

Under the current system, I'm sure all of us in here know way too many families who've had to impoverish themselves or their family members in order to secure Medicaid eligibility to get long-term

services and supports. Individuals lose everything and they become impoverished essentially for a lifetime and couples often divorce. It's time to assist people to avoid that impoverishment and at the same time take pressure off the Medicaid system because it has become the default long-term services program in our country.

As we know for years, Congress has spent a lot of time over the last couple of decade in attempting to prevent people from transferring assets to qualify for Medicaid but hasn't really offered a good alternative to the Medicaid program. From our perspective, the CLASS Act offers a very meaningful affordable way for individuals and their families to cover the cost of long-term services and supports based on functional need not on diagnosis.

It allows the individual to live as independent a life as possible, allows them to continue to work and participate in their communities. It does not require spend down and lifetime impoverishment for

necessary supports. It allows individuals and the family members to spend the funds as they see best meeting their needs and it does not create or foster institutional bias for services.

It essentially presents an opportunity, as Connie said, for choice, dignity, and personal responsibility through an insurance-based model. Our bottom line is that it allows people to avoid the Medicaid system. It's the front end of some changes that are very much necessary. It is complimentary to basic health insurance coverage and we believe that it could be complimentary to private long-term wraparound insurance policies also.

We also see the CLASS Act in the context of being quite complimentary to the other changes that have been mentioned earlier that are included in the Senate Finance Committee's package to improve home and community-based services in the Medicaid program.

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We believe the CLASS Act addresses the front end of the problem, helps people avoid Medicaid as long as possible or completely if that's possible and encourages people to choose to purchase coverage early in life but we do believe it has to be complimented by improvements to the Medicaid program for those who are eligible for that and to improve the community-based services and end the institutional bias in Medicaid.

Judy and Nora both have mentioned that there are several provisions in the Finance Committee bill, which would help us to move in that direction. One being the Community First Choice option and there are several other provisions that move towards that and open up opportunities and encourage the states to provide more community-based services.

Both the CLASS Act and the Senate Finance Committee provisions, we believe, are necessary and complimentary elements of health care reform and they must be included and I will echo what Nora has done and

say if you're interested in these and you're watching, you should call your members of Congress. Thank you.

DIANE ROWLAND: Thank you to all the panellists and to the initial speakers. We just heard from Larry a new title for this. Instead of the sleeper issue, I think it's the CLASS Act, from beds to vans [laughter]. So thank you for that contribution. I'm going to open it up now for those of you in the audience who have been very patient to ask your questions. If you could raise your hand, we have mics that'll come to you and identify yourself when you pose your question. So we'll start in the back and then we'll move to you in the front.

JOHN GREEN: Hi. I'm John Green with the National Association of Health Underwriters. This is for Connie. Hi Connie. So for members of Congress, long-term care is always number four on their top three list and so when the CLASS Act moved to the Finance Committee, unfortunately though 125 provision that your

good, and your office accepted on that issue of number four on the list, got stripped out because of amendments that members wanted.

So the tax issues are finance's responsibility but what are the prospects, when they're merged, to reinsert that because you're so good on that issue for us and we really appreciate you carrying that water thanks.

DIANE ROWLAND: Connie?

CONNIE GARNER: You're right. What the provision that's being discussed is this provision called a cafeteria plan. We have continuously and really do believe that this CLASS Act needs to work in concert with the private insurance industry products and do something to help jump start the market place that they're having trouble with and we don't want to see that happen. So one of the things that we have tried to support and we did have it in our HELP committee bill was this cafeteria plan.

What that would mean would be when you were working with your employer and your benefits that you would be able to see on your benefit list long-term care insurance to purchase as well. I think it would be pre-tax dollars, am I right? That's where the cost is. It's in the pre-tax dollars, yes. It would be in the pre-tax dollars just like it would be for your health insurance.

Now we argued that that was an important platform for the long-term care insurance industry and particularly if we had CLASS Act to be able to develop the entrepreneurial wraparound products that we would hope would be developed and have the CLASS Act and the private insurance product work together.

We did have it in our HELP committee bill and we actually had tax credit in our HELP committee bill as well. Both provisions were taken out mostly because of jurisdictional issues, not because of lack of support but I do understand that in the Finance

Committee, it was the result of money and the cost associated with the pre-tax dollars.

I will tell you I did bring it up at one of the merge meetings that we had last week and the rationale for why it was important to have an arguable platform for the insurance products as well as CLASS Act. So I'm not sure it's off the table but it's certainly in part of the discussion and that's kind of where it's at right now John.

DIANE ROWLAND: Next question.

BOB ROSENBLATT: Bob Rosenblatt, freelance writer. I'd like to ask are there any restrictions on how the $50 or $75 can be used. Is it a pure cash benefit? Will HHS have the ability to put in regulations? I'm thinking about let's say in 10 years, the program is up and running, a lot of people are involved and a lot of young people are getting benefits and inevitably there will be stories saying that someone who is in college is now using the money for

other than personal services and support. Does this pose a problem for any of you?

CONNIE GARNER: I can just tell you from the development of the legislation that this, any time you have a cash model, these kinds of issues come up. We challenged, what happens with the old age survivor checks. That's an insurance-based model you contribute to in your pay check and when you get older, you're able to get that reimbursement.

I have yet to see anybody telling my mom she has to use it for orthopaedic shoes as opposed to what else she wants to. This is not a poverty-based model and that was the reason that we developed it this way.

However in the legislation, you'll see that the intent of the legislation is for people to be able to purchase the services and supports they need to be able to live in the environment that they think will be helpful to them. So if they are in assisted living where you really are paying for the shell and the roof

over your head and the meal and anything beyond that you need to pay for, this would be a resource to them.

For those that are home and community-based living in their neighborhood, in the house, in their kids' house, this money is intended to be used for the services that would help take some of the burden off of the family but also give them what they need. We do have a suggested list of what those services should be.

It's an included but not limited to list of services and I think we have left certainly the door open for HHS to be able to look at that but the intent, if asked, if asked, we would have to say the Congressional intent of this is really to give people the freedom to self-determine what their needs are.

Our experience in having worked in the disability community for a long time now, our experience has been when you have a person who has a disability, the last thing that they really want to do

and particularly the younger people, is stay home and really kind of work over the system.

We don't see that. We don't see that with the vets that come back. We've looked at them through home health and visiting nurses. We've looked at the disability community, the traditional disability community. They want to have what they need to be able to stay productive and have choices about their life. So that given that it's an insurance-based model, we would hope that whatever regulations came out would never hamper that ability of that free choice.

JUDY FEDER: Just note in that and another provision in the Senate Finance mark that is important to people is that there are issues of how you find the services that you need. We know there's a need for investment in the systems to make sure that people can find those vans.

So there is another provision that provides additional support for aging and disability resource

centers that can be a tremendous asset for people who are looking for services in communities. So I think that developing those resources in communities is very important alongside the enhancement of support for actually paying for them.

DIANE ROWLAND: And Bob, I'd just add that your college student would have to meet the disability criteria to be able to access the benefits so that it's not that I could decide that I wanted to use the benefit unless I had two or more ADLs or other limitations. So you would be getting a population that has really needed the benefit. So there's a double gateway there. Next.

RICHARD FRANK: There's also counseling and support services to help guide people.

DIANE ROWLAND: One, two. Okay.

STEVE MOSES: Steve Moses, Center for Long-Term Care Reform. Just an observation to begin. No opposition to the CLASS Act on the panel. It'd be

interesting to have gotten the kind of other side of the story. Specific question, what about the percentage you expect to opt out? Brown and Finkelstein have said that 65-percent to 90-percent of the market for long-term care insurance is crowded out by the availability of Medicaid. I'm wondering why the market for the CLASS Act option wouldn't be also crowded out for the same reason.

CONNIE GARNER: Well I think as we developed it, our hope is this. First of all, on the participation rate that we have on this program, we have a very, very, very conservative estimate. We feel like we came out with relatively good numbers and in consideration that it was conservative because it can only really go up.

In terms of the participation rate and all the different studies, and I think Larry can talk about what the participation rate would have been in the Moran study or the Mercer study that was done but in

terms of CBO, because they have to use the data that they have, the current experience data.

They gave us the same participation rate as the long-term care insurance industry, which we had a little bit of a challenge on with them about that but it's fine because it turned out fine, which was only about five-percent, with the reason that we argued was that it was, we are looking for a voluntary opt-out. So you're in unless you choose to say you're not in. So where's the credit for that?

The second piece of it is that again and I think this gets to your issue, why would Medicaid not crowd it out? Because this is a different term that we're going to use, this applies, and we will market it as applies to individuals under 65 as well as over 65 that have functional limitations. It's a cash benefit. It has no underwriting. It's a benefit that you will have for life.

So I think there's a lot of incentive to try to do this that might be there in the market place right now, therefore Medicaid's the only game in town. So we would hope that the structure of this would be much more of an incentive than having to go on Medicaid to get your help.

HOWARD GLICKMAN: Howard Glickman with The Urban Institute.

RICHARD FRANK: Can I just respond? I think a couple of things that Connie didn't cover, one is it's a cash benefit. It's a lifetime benefit, which is different than what you see in the market place today. There's a public endorsement of it that will be part of it, which we've seen a little bit when we analyze partnership programs is actually helpful.

Finally, if you read the Brown and Finkelstein paper carefully, while they say there's important crowd out, they also say that tone of the really unsettled and open issues is what the role of an opt-out would

actually be in helping to offset some of the irrationalities in the market. That's the big open question that they leave on the table.

LARRY MINNIX: I think this question gets at the heart of sort of the public's readiness to do this. We got a problem that 70-percent of the people face and nobody wants to talk about until it's suddenly your mother or your child. What we found in our focus groups and other things is that younger people, especially, are ready to talk about this and willing to pay because they've seen these issues in their own family. They've seen what it's done to the family pocketbook, family stress.

So I think the time is right from a public acceptability standpoint. If you have a choice, what's wrong with having a choice to put your money in a national consumer financed insurance pool to give you a hedge on something that's likely to happen in your family in your lifetime. So it begins to be kind of a

reasonable thing for people to do. How many of us want to go on Medicaid? Can I see those hands?

So I want to be crowded out by Medicaid. How many of us want to give up our assets? Okay. I don't see any hands on that. How many people think there's going to be more Medicaid dollars skewed toward nursing homes in say the next five years? Can I see the hands on that? Well then we got to have an alternative and we've got something here that actually makes some sense the way the consumer thinks about it once you talk it over with them.

So I think there's a lot of discussion about numbers and it's really about power struggles and control of things but there's something here that's sort of fundamental that makes a lot of sense to a lot of families.

DIANE ROWLAND: Howard?

HOWARD GLICKMAN: Howard Glickman with The Urban Institute and Kaiser Health News. I'd actually

just like to follow up on that question and kind of turn it around and ask Connie and Mr. Frank both what do you think the participation rate actually would be at $120 a month premium?

CONNIE GARNER: Do you want to go first?

RICHAD FRANK: No, you go first [laughter].

CONNIE GARNER: Well it's good I have Paul here to help me out. I think given the fact that we have surveyed this, given the fact that this hasn't been a piece that's been developed in a room by a bunch of staff people that really has been developed by the mainstay true consumers that have to pay the premium. $60 every two weeks of the $123 doesn't seem to be an issue. We have not had kickback about that.

I think the reason for that and I think the reason why it warrants a second look at whether that's too expensive or it's not is because of what the benefit has to offer you, the value of the benefit given the fact that you can have a predictable premium

and the value of the benefit in that it increases with CPI each year, one can argue, makes it worth the cost of it right now and frankly, we've just gotten our hands on some information.

It's generally proprietary but I don't know how we got a hold of it, around what the products are that are out there right now, what the cost of those products are, what the uptake is, what the private margins are on them.

I don't think we're out of the ballpark really in terms of what's out there in the private industry. If you think about that in terms of no underwriting, this is nothing. I mean if they scored it $75, that's $2,250 a month. If you subtract the $123-120, $2,250 a month, you're still going to clear $2,150 or $2,100 a month at least for 12 months with no holds barred.

So I think that's where people are looking. We had some interesting things we did in our office with our interns where you can get on the computer and

you can say if I'm a 21-year old and I'm perfectly healthy, how much will be my premium? This is with the OPM federal program. The one person typed that in and she got $10 a month and then I said now be 29 and be married, be 29 and don't have a whole lot wrong with you. So she put that in and that got up to $140 a month.

Now the person who works right next to me who's one of our directors who is perfectly healthy, runs five miles a day but happens to have diabetes type 2, which is very controllable as you know, it's not insulin-dependent diabetes, is $390 a month for a plan that for him is very time-limited.

So I think when people, if they really in the market place, kind of look at this stuff, we don't feel like we're out of the market place. The other thing that's been interesting is this is not an employer mandate. It's also not a mandate on employers to contribute to this.

However, we have had several calls that have come in over the years from the employer people and saying can you contribute if you want to. Well you can do what you want as an employer. If you feel it's worth it for your employees' benefits to contribute some to the premium, you're welcome to do that. That mandate is not coming from the government.

So there may be some of that that goes on as well. So it's one of these programs that you just have to try. I just have to add one other thing though, which I think is the most compelling piece of all this for us. This is the first time and I've been maybe 20, a little over 20 years working with the disability community, both in the Clinton administration and now up with Kennedy for 16 and so I've worked a lot with the aging community and a lot with the disability community.

This is the very first time that I have ever seen both the disability and the aging committee come

together and say we want to be accountable. We don't want to go on Medicaid. You don't have the right to take away the personal responsibility that we want to have to have some part in solving our own issues and building the future. It's the first time, I think, we've ever seen this.

We had a conversation with the member level about this. I think it resonates that it's the first time the two most vulnerable populations have stood up and said this is important to us and you don't have the right in something that's not going to cost the government any money to take away our sense of personal responsibility and our right to be part of that. I think that's a big piece that resonates in all of this. I would hope that the premium would not stand in the way of them.

JOSH WIENER: Hi, I'm Jose Wiener, RTI International. Could you say a little bit more about the subsidy that would be provided for the low-income

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population because it seems to me that there's a substantial gap in affordability between the people below the federal poverty line and the people, for whom the premium at $1,500 a year, for whom that would be two or three or even five-percent of their income. What is the relationship between the subsidy and Medicaid.

CONNIE GARNER: Okay. There's actually no subsidy. We did not do any subsidy here. So it's not the same model as the basic acute illness and injury coverage conversation that's gone on but I think it's a fair point. I think we have to start somewhere and this was our place to start. We would hope that employers will contribute. We would hope that people would see it as important. We would hope that families would contribute if their kids in their 30s need to have it. They may or may not but you have to start somewhere.

What we did was internally offset the two groups that we felt were the most important to offset, one where the young people that were coming into now their own in terms of both reinforcing the value that they may not know who they are 24 hours from now and they need to care about that and the other are the individuals who are clearly poor and under 100-percent of poverty and they work. Why do we want them to fall down instead of up? What's most interesting about our score and this is why I think over time and again that premium may change.

If we get more of it, we expect to see more than five-percent participation rate in the end of the day. That premium was scored at five-percent participation rate and $75 a day. If that participation rate goes up and the remodelling that each HHS does, that premium could be way less than that.

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There are ways to design this where the premium would look less but what we wanted to do is make sure that people had predictability about the premium for those people who are risk-averse who really cared enough to look ahead. We wanted to make sure we offered them that kind of predictability in the premium. So I think we've sort of kept to our promise in terms of philosophically what we thought was important.

The one thing that I'll tell you is the most interesting to us in the score is we never expected to see Medicaid savings in the sixth year of that 10-year budget window. We really didn't think we would see Medicaid savings until the second decade or the third decade but on year 6 through 10 of a 10-year window where the first five years is just paying in premiums, you begin to see the Medicaid savings to the tune of right now, $1.2 billion in 10 years.

That tells us there are people working who should have to meet a work requirement even though it's a marginal work requirement who are working who are still going to Medicaid because it's the only option that they have.

So I think we're comfortable because you have to start somewhere and we're comfortable that we've protected the two groups that we think are most important to protect coming out of the gate with this.

DIANE ROWLAND: Okay.

EILEEN TELL: Hi Connie. I just had a clarifying question. Sorry, Eileen Tell with Long-Term Care Group. Just in terms of the program mechanics, I have two quick questions. One is you talked about the sort of a penalty if employees wait to enroll.

So for example, if I enroll in the fifth year, I'm employed as opposed to the first year it's available, is the premium higher because the benefit's higher so it's proportional increase to what the CPI

benefit would be or is there an added kind of penalty charge on top? That's one question.

Then the second one is just whether employers have an option to opt-out of the program or is it mandatory for employers to offer it? Thank you.

CONNIE GARNER: Let me take the first question first or the second question first. Can employers opt, yes it's voluntary opt-out for the person. It's totally voluntary on the part of the employer. Now we've talked to the employers about whether it was important for us to mandate that they do a payroll deduction as another line on their computer of their paychecks. We talked about Paycheck about how complicated would it be to add one more line on to it.

Although that process is not complicated at all from the employers' input that we got. There was no real reason to do that. If their employers are interested in this then they'll do the payroll deduction. It's not that big of a deal.

So yes, the employer can say I don't want to do it, in which case, there'll be a mechanism set up by, there's intended to be a mechanism set up by HHS to be able to provide for people to pay their premium but I don't think we didn't have a sense, we certainly didn't have a sense strong enough that we needed to mandate auto-enrollment given the feedback that we got from the employers. So that's the answer to question number two.

Question number one, why did we essentially ding people that didn't get in the first year? We want to see that participation look in those first couple of years because we think that's important in terms of determining the solvency of the program and the uptake, the participation rate in particular, which is why that five-percent, we just swallowed and that was fine because we feel like it could only become better than that.

When you get, I don't even want to say the penalty but the cost to you if you get in later is going to be that increase in the CPI put on it and then your question is, you also get a higher benefit?

It's going to depend on what year you come in because again, as you know, the benefit goes up each year with CPI for those who get in the premiums level but if you get in later, you're going to get that CPI tacked on with the premium would be that year and then you'll get whatever the benefit is that year as well. So hopefully Eileen, that answers your question.

MORRIS TENNENBAUM: My name is Morris Tennenbaum. I am a proprietary provider in New York City, nursing home provider, and I'm also the chairman of the New York State Health Facilities Association offshoot, which is a foundation for quality care but really personally I'm here as one person, my think tank, and I still, basically from what I'm seeing, I

still have questions when you talk about five-percent participation, whether that really solves the problem.

I have really come up with an alternative that I can share with you obviously only in 20 seconds and that is essentially over 70-percent of the population has life insurance in one way, shape, or form, or the other.

I would suggest that you call it dual purpose life insurance and have it back ended by a partnership and that would cover a lot of people and I would suggest the New York State Partnership, which is basically a time-based one, which says two-and-a-half to three years in a nursing home or five to six years in home care, which covers HCBS because the consumer choice, everything's available. You have a lot of it, increase some of it, and it covers every single concern that was mentioned here on all parties.

So if anybody really wants, I have it written up, I don't have that many copies of it but I would be pleased to share it with anybody that asks.

DIANE ROWLAND: Always useful to have new options on the table and we had one other question here and then we have one in the back of the room and then we're going to have to wrap up.

BOB ROHR: Hi, I'm Bob Rohr with BMJ. I understand the five-year limit of collecting premiums before you start doing payouts but when say in year seven or 10 or whatever, if a new person joins, do they immediately qualify for benefits or do they also have to wait a five-year period from their initial enrolment? The second question would be with regard to investments of the premiums there, would that be limited to T-bills or something like that or would it be open and mixed?

CONNIE GARNER: Okay. Let me answer your second question first in terms of where's the money

going. We had lots of conversations originally about this. We had a lot of questions about whether you could do this as a quasi-governmental agency, whether you could do it similar to a TSP account where you really had some investment go on. We first began to do this, it was around the time that the social security kind of conversation was going on.

So we kind of wanted to stay away from that but I think we've left enough lee-way to the administration, HHS, to decide what's the best way to do that that number one, certainly number one, protects those dollars so that they don't get used or they don't get lost in risky investments.

The second thing is they have enough flexibility there to design a lot of the operationalizing in the program, which I would argue doesn't preclude this kind of life insurance to the last question, kind of looking at entrepreneurial ways to begin to merge this with other products. I think

that there's room for that kind of conversation I would hope that they would have.

So right now, really it's up to the administration what to do but it wasn't as if we did not have these conversations about different ways that you could kind of look at this. For our purposes, it would have taken a big strain off of some of our conversations if we didn't have to worry about budget order points and things like that, points of order.

The first question that you had was, now tell me that one again, seven years? If I get in today, okay, and I'm employed then I need to pay in for five years and on five years, one day for example, I am able to collect my benefit if I show, number two, that I've met the functional limitations that are necessary to qualify, you'd actually get the benefit.

So your question was you always have to pay five years, yes, yes. You always have to pay five years. Now there's another little piece that got into

this that is important to think about as well. If I were you, I'd be asking do I have to work all those five years or do I not have to work all those five years and our original bill, we did not have any work requirement within that five-year period.

One of the pieces that really was helpful that we had gotten from some of the analysis was you're going to wind up with more adverse selection if you don't tighten that up a little bit. So what we did was we said of the five years that you're paying in, you have to meet the work requirement three years of those five years.

We didn't want to do the whole five years because there's a number of people out there that would want to retire. They couldn't if they had to continue to work even though one might argue it's only $1,000 a year and you could drive a school bus or do taxes for some, there's other ways that you could make it without your traditional full-time job but you would always

have to pay in for five years, three of the five need to be working time.

BOB ROHR: Alright, this is sort of a follow-up on that then. Assuming one pays in for five years, invests, and then for one reason or another drops, if one then picks it up again, is there a new five-year vesting period or not?

CONNIE GARNER: You do get credit. If you get back in within a timeframe, this is really the devils in the details and I honestly can't remember what we agreed on at the end but there is a time, but if you get in within a certain period of time then whatever the years are that you had already accumulated get credited.

So if I contributed three years and then dropped out and got back in, I'd get credit for those years and I'd only have the additional two. Now if you get outside the window enough and I think it was seven years, I'm not sure, you get outside the window enough

then it's just like any other insurance plan. That's sort of it.

DIANE ROWLAND: Okay and one final question.

KARL POLZER: Karl Polzer National Center for Assisted Living. I just wondered if there was any discussion about how employers or unions might respond and would they be allowed to contribute on behalf of individuals? Would that be pre-tax and would there be nondiscrimination rules about which employees you might do it for given the issues that Josh surfaced about income?

CONNIE GARNER: Again we didn't mandate any of that but we didn't preclude that employers couldn't contribute for their employees if they chose to. Now to get into an antidiscrimination issue then I think that's an issue that you would have to look at as employers chose to be able to contribute because I don't think you could discriminate. That's like not my area.

So we would have to see that but we did not, to answer your question, we did not preclude employers from being able to contribute on behalf of their employees. We just did not mandate they had to do that.

DIANE ROWLAND: Well I think we have had a very full time here and a very full discussion and I want to thank each and every one of our panellists for coming but especially the audience for being here as well. Thank you [applause].

[END RECORDING]

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